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	17E630	A. BUILDING _____ B. WING _____	05/02/2012

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ANTHONY COMMUNITY CARE CENTER	212 N 5TH AVE ANTHONY, KS 67003

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F 000	INITIAL COMMENTS The following citations represent the findings of a Health Resurvey and Complaint Investigation #54372 (LFP811).	F 000		
F 170 SS=E	483.10(i)(1) RIGHT TO PRIVACY - SEND/RECEIVE UNOPENED MAIL The resident has the right to privacy in written communications, including the right to send and promptly receive mail that is unopened. This REQUIREMENT is not met as evidenced by: The facility census totaled 35 residents. The facility provided mail delivery service to 22 of the residents. Based on interviews, the facility failed to ensure 22 residents received prompt mail delivery service by not delivering mail on Saturday. Findings Included: - During an interview at 1:30 pm on 4-23-12, resident #8 reported the residents in the facility did not receive mail on Saturdays. The resident indicated the staff person responsible for this task did not work on Saturdays. During an interview at 8:15 am on 4-24-12, social service staff F revealed residents received the mail Monday through Friday but not on Saturdays. He/she reported he/she was the individual responsible for obtaining and delivering mail to the residents. Staff F reported the post office delivered mail to the community of Anthony on Saturdays and placed the facility mail into a	F 170		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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F 170	Continued From page 1 locked box. Staff F indicated the residents received Saturday mail on the following Monday when he/she returned to work. During an interview at 12:30 pm on 4-25-12, administrative staff G confirmed the residents' mail delivery service is Monday through Friday. He/she reported the residents did not receive mail on Saturdays and confirmed the post office placed Saturday's mail into the facility post office locked box. He/she said staff delivered the mail to the residents the following Monday. During an interview at 3:00 pm on 4-26-12, licensed nurse E reported he/she did not find the facility policy or procedure for resident mail service and did not think the facility had one. The facility failed to have a system in place that allowed residents access to prompt delivery of the mail on Saturdays.	F 170		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: The facility census totaled 35 residents. Five new employee records were reviewed and 3 of the 5 sampled records revealed the facility failed to develop a policy including reporting alleged violations of abuse, neglect, and exploitation to the proper authorities immediately and failed to	F 226		

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F 226	Continued From page 2 implement the screening portion of the policy. Findings included: - On 4-26-12, review of the personnel record of housekeeping staff hired on 2-17-12, revealed the facility failed to conduct a criminal background check for this new employee. On 4-26-12, review of the personnel file for the direct care staff hired 2-27-12 revealed the facility did not conduct the nurse aide registry verification until 4-24-12. On 4-26-12, review of the personnel file for the licensed nurse hired on 2-13-12, revealed the facility did not conduct the licensure verification from the Kansas Board of Nursing until 4-24-12. On 4-26-12 at 11:40 am, licensed staff E confirmed the personnel record of the housekeeping staff lacked the criminal background check information, lacked the nurse registry verification for the direct care staff, and did not contain the licensure verification from the Kansas Board of Nursing for the licensed nurse. He/she indicated the employee files were incomplete and indicated the facility failed to follow their Prevention/Prohibition of Resident Abuse policy, in particular the screening and background checks of new employees. Staff E also confirmed the facility policy did not indicate the appropriate authorities would be notified immediately of an alleged abuse, neglect, or exploitation situation. Review of the facility policy, Prevention/Prohibition of Resident Abuse dated	F 226		

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F 226	Continued From page 3 02/01/05, revealed the facility would perform backgrounds checks, references, and would follow their Personnel Policy and Procedure Manual on all applicants and current employees. The abuse policy section I. revealed, "if the accusation is substantiated, the employee will be terminated and reported to the appropriate state licensing agencies and other proper authorities, as warranted, within 24 hours of the decision". The facility failed to develop a policy to immediately notify the proper authorities, including the state agency of all allegations of abuse, neglect, and exploitation. The facility failed to implement their prevention/prohibition of resident abuse policy by not thoroughly performing new employee screenings and failed to develop an abuse policy informing staff the appropriate authorities would be notified immediately during an abuse, neglect, or exploitation allegation.	F 226		
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: The facility census totaled 35 residents. Twenty residents resided on the North hallway. Based on observation, interview and record review the facility failed to provide housekeeping services necessary to maintain a sanitary and comfortable interior for 20 of 20 residents who resided on the North hallway regarding strong offensive urine	F 253		

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F 253	Continued From page 4 odors that permeated the North hallway. Findings included: On 4/19/12 at 8:30 a.m. during initial tour, observation revealed a strong offensive urine odor on the North hallway near the soiled linen carts and trash parked midway down the hall. The linen and trash carts contained bagged soiled contents, filled to the top of the carts. The carts presented with a wicker weaved material and the lids failed to fit tightly. The strong offensive urine odor permeated to the end of the North hallway. On 4/23/12 at 7:15 a.m. observation revealed the wicker linen and trash carts sat in the North Hallway with a strong urine odor present. Observation on 4/23/12 at 1:39 p.m. revealed resident #3 sat in his/her recliner chair. A strong urine odor permeated the room. On 4/23/12 at 3:30 p.m. observation revealed the urine odor was less noticeable and the wicker linen and trash carts contained no soiled linen or trash. Observation on 4/24/12 at 7:30 a.m. revealed the urine odor was again strong near the trash and linen carts that sat in the North Hallway. At 11:00 a.m. and again at 12:40 p.m. observation revealed the laundry and trash in the wicker baskets remained full of soiled linens and trash. A strong urine odor persisted in the hallway near the wicker baskets. On 4/24/12 at 7:46 a.m. observation revealed	F 253		

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resident #3 ambulated in his/her room independently as he/she dressed himself/herself. A strong urine odor continued to permeate the room. At 8:18 a.m. the resident's unmade bed presented with a pillow top mattress with brown stains that covered about 2/3rds of the mattress surface. A strong urine odor continued to permeate the room. After leaving the room with the door closed, the strong urine odor permeated the hallway. At 11:52 a.m. observation revealed the resident sat in his/her recliner and the strong urine odor remained in the resident's room and his/her bed remained unmade. At 2:06 p.m. observation revealed the resident's closet presented with 4 water resistant mattress pads on the top shelf. The resident's bed remained unmade and a strong urine odor permeated the room.

On 4/26/12 between 8:30 a.m. and 9:30 a.m. the environmental tour included the following observations and interviews:
The north hallway contained new soiled linen and trash barrels with tighter lids. The stale urine odor was less but still lingered near resident #3's room. Maintenance staff I reported he/she knew about the odor problem since January 2012. He/she reported the family brought in a new mattress and box springs and he/she removed the old one, cleaned it and stored it in the maintenance building. Staff I stated the maintenance building presented with a strong urine odor for a while but became less because he/she shampooed the mattress and air dried it. Observation in the maintenance building at approximately 9:15 p.m. revealed a mattress leaned against box springs and presented with a large dried brown spot that covered 3/4's of the

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double bed mattress. Staff I confirmed that the mattress and box springs belonged to resident #3. Both the box springs and the mattress smelled of a stale urine odor. Staff I reported that once the smell was in the inside of the mattress it was hard to get rid of without just buying a new mattress and box springs. When asked how often he/she changed out the mattress, staff I reported he/she had not changed out the mattress since January when the family brought the resident a new pillow type mattress set. Staff I stated he/she was the only person who would change out the mattress and that to his/her knowledge housekeeping and nursing had not changed out the mattress as he/she had not cleaned the pillow mattress set since the family brought it for the resident. Staff I reported that housekeeping cleaned the resident's room daily and was to spray the mattress with a disinfectant and let the mattress air dry in the resident's room daily. Staff I reported that the return air duct was right outside resident #3's room and that the air system would pick up the odor and carry it to other rooms on that hallway. At 9:30 a.m. staff I reported that resident #13's room also had a urine odor because the resident's urostomy leaked and urine got on the carpeted floor. Staff I reported that he/she shampooed the resident's carpet at least once a week. He/she confirmed that all the rooms received a deep cleaning once a month. Staff I provided a cleaning schedule that included a list of resident names and room numbers that staff had crossed off when they completed cleaning the resident's room. Staff I reported he/she did not have a cleaning schedule for resident #3's shampooing and rotation of his/her mattress.

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During an interview on 4/23/12 at 4:38 p.m. direct care staff A reported resident #3 had two mattresses and that the facility changed them out every so often, steam cleaned and aired them outside. He/she also reported the resident had plastic covers to protect the mattresses from getting wet.

On 4/24/12 at 8:20 a.m. during an interview direct care staff O reported the bedding for resident #3 consisted of placing extra incontinent pads on the top of the mattress, then a mattress cover, then more incontinent pads, then the bottom sheet, and then additional incontinent pads.

On 4/24/12 at 10:40 a.m. interview with housekeeping staff J revealed he/she cleaned all the resident's rooms daily. Staff J reported he/she did not wash beds and that was a part of the aides' responsibilities. He/She reported the facility deep cleaned all the resident's rooms monthly. When asked about the urine odor in resident #3's room staff J reported the resident had his/her own bed and mattress and the strong urine odor was because the resident was incontinent. Staff J stated that he/she did not clean the resident's mattress or bed except to spray it with Lysol disinfectant every day.

On 4/24/12 at 12:30 p.m. administrative staff G, during an interview, regarding the strong offensive urine odors on the North hallway, said he/she had suspected the wicker linen and trash carts for a while now but because of culture change and the desire to a more homelike atmosphere he/she did not remove them from use. Staff G reported that he/she had bought multiple plastic covers for resident #3's bed and

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staff were to use them. Staff G also reported that he/she wanted to get the floors stripped and clean because he/she thought the flooring material retained the urine odor. Staff G provided no time table as to when the staff would start or complete the floor stripping and cleaning.

On 4/24/12 at 12:42 p.m. direct care staff A provided additional information that the facility shampooed and steam cleaned resident #3's mattress weekly. At 12:45 p.m. staff A reported he/she was well aware of the strong urine odors on the North hallway. Staff A reported he/she believed the odor was coming from resident #3's room.

On 4/24/12 at 1:00 p.m. during an interview with direct care staff C revealed he/she let resident #3's bed air out so that it was dry before he/she made it later in the day.

During an interview with housekeeping staff P on 4/26/12 at 7:04 a.m. revealed housekeeping staff sprayed resident #3's mattress every day with Lysol. He/she reported the facility had shampooed the mattress a couple of times. Staff P reported that it was his/her understanding that another mattress was outside in the shed that maintenance staff I switched out. Staff P reported he/she did not know how often maintenance staff I switched the mattress out but that maintenance staff I said he/she could do it anytime if the staff just let him/her know.

The facility failed to provide housekeeping services necessary to maintain a sanitary and comfortable interior for 20 of 20 residents who resided on the North hallway regarding strong

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F 253	Continued From page 9 offensive urine odors that permeated the North hallway.	F 253		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: The facility census totaled 35 residents. The sample included 17 residents. Based on observation, interview and record review the facility failed to develop a comprehensive care plan for 2 of 17 sampled residents regarding hospice services (#1) and restorative care (#18). Findings included:	F 279		

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- Review of resident #1's signed physician's orders dated 3/31/12 revealed the following diagnoses: gout, congestive heart failure, COPD (Cardio Obstructive Pulmonary Disease), DM (diabetes mellitus) without mention of complication, macular degeneration of retina, chronic pain, constipation, atrial fibrillation, chronic kidney disease, sleep disturbance, allergic rhinitis and GERD (gastroesophageal reflux disease).

Review of the resident's significant change MDS (minimum data set) with an ARD (assessment reference date) of 4/15/12 identified the resident with a BIMS (brief interview of mental status)of 00/15 (severe cognitive impairment), required extensive assist of 2 persons for bed mobility, transfers and dressing and received hospice services.

The comprehensive care plan dated 4/17/12 included a problem description that included the following information:
The resident was re-admitted to the facility on 4/4/12 with supplemental Hospice services. During and since the hospital stay the resident experienced fluctuating alertness, level of consciousness and mental status. The resident experienced disorganized thinking, inattention, psychomotor retardation and lethargy. The summary included that the resident was given a larger room to accommodate family members who stayed with the resident 24 hours a day and did so by their own choice. It included that the resident made decisions about Hospice care with his/her family and had lived his/her life and was ready to die. The resident's care plan failed to include any interventions related to the

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coordination of care between the facility and Hospice agency.

On 4/23/12 at 2:55 p.m. observation revealed the resident lay in his/her bed with his/her eyes closed and resting comfortable. The resident displayed no signs of pain. The resident's facial expression was peaceful. The resident laid on his/her right side with his/her call light within reach.

On 4/23/12 at 4:00 p.m. observation revealed the resident lay on his/her back. The resident remained with his/her eyes closed and without signs of pain. Family remained at his/her bedside.

On 4/23/12 at 3:15 p.m. family member Q and R reported that a person from the family remained in the resident's room 24 hours a day seven days a week as this was the resident's wishes. Both family member Q and R reported satisfaction of the Hospice services being provided to the resident. Family member Q reported he/she did not think the facility staff always checked his/her [the resident]'s pad as often as they should. Family member Q reported it depended who was working but when family asked for staff, family member Q stated the facility staff was prompt on all their requests. Family member R reported overall staff was very loving.

During an interview on 4/23/12 at 4:35 p.m. direct care staff A reported he/she worked both hallways. Staff A was aware of the resident's condition and reported the resident required total care with his/her activities of daily living. Staff A reported that when the resident needed supplies

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provided by Hospice, he/she let the charge nurse know.

On 4/24/12 at 4:05 p.m. direct care staff K when asked how he/she knew what Hospice supplied for the resident, he/she stated that Hospice brought the supplies to the facility and put them in the resident's closet so he/she just checked the closet and knew then what Hospice supplied.

Hospice staff S during an interview on 4/23/12 at 3:00 p.m. reported when he/she entered the building he/she checked with the nurses then visited the resident. He/she reported that he/she checked in with the nurses again at the end of his/her visit. Hospice staff S reported he/she provided the facility with a medication sheet that listed the resident's medications Hospice provided. Hospice staff S stated the Hospice agencies care plan included what Hospice provided but he/she did not know what was on the facility's care plan. Hospice staff S reported Hospice provided the facility with the Hospice agency's care plan for the resident. Staff S reported the home health aide usually brought the supplies, a nurse visited two times a week and the home health aide also visited 2 times a week. Staff S reported that a social worker and chaplain from Hospice come once a month and as needed. Staff S reported the home health aid provided turning and repositioning on her visit along with transferring the resident. Staff S reported transferring had not happened in the last 2 weeks due to the resident's declining condition. Hospice staff S also reported that the home health aide provided bed baths to the resident twice a week along with hair care, lotion, pericare/catheter care. Once a week the home

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health aide provided nail care and with every visit provided oral care. Staff S reported the home health aide also changed the linens on the resident's bed on the days he/she bathed the resident.

On 4/24/12 at 4:00 p.m. nursing staff D reported he/she spoke to the Hospice nurse and aide before and after visits. He/She reported that pain medication was given before the home health aide provided care Staff D reported he/she did not know what hospice supplied but the Hospice nurse always asked him/her if the resident needed anything and if we [facility staff] told them [hospice staff] what the resident needed and the hospice staff brought it in for the resident.

On 4/24/12 at 4:15 p.m. interview with nursing staff L revealed he/she only included on the care plans only the main or current issues that pertained to the resident's immediate needs. Staff L stated he/she did not have time to care plan everything about the resident as he/she was only one person. When asked how staff would know what services such as additional baths, personal care, or supplies Hospice provided, staff L reported it was common knowledge and was communicated between the Hospice and facility staff but confirmed that was not included in the comprehensive care plan.

During an interview on 4/24/12 at 5:15 p.m. administrative staff M reported he/she would expect to see the coordination of care with Hospice on the care plan.

The facility provided no policy for care planning the coordination of care of Hospice services.

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The facility failed to develop a comprehensive care plan to include the coordination of care for a resident who received Hospice services from an outside agency.

- Review of resident #18's signed physician orders dated 4/1/12 revealed the following diagnoses: multiple sclerosis, constipation, muscle weakness, other behavioral problems, insomnia, depressive disorder, spasm of muscle, pain, and hyperlipidemia.

Review of the resident's most recent quarterly MDS (minimum data set) dated 2/29/12 identified the resident with a BIMS (Brief Interview of Mental Status) score of 15/15 (cognitively intact), required extensive assist of one person for bed mobility, transfers and required extensive assist of 2 people for dressing and toilet use. The MDS also identified the resident as not steady and only able to stabilize with human assistance with moving from seated to standing position, moving on and off toilet and surface-to-surface transfers, experienced impairment on both sides of lower extremities and used a wheelchair for mobility. The MDS identified the resident experienced no pain and received ROM (range of motion) active and passive 5 days in the last 7 calendar days for at least 15 minutes a day.

Review of the annual MDS dated 12/7/11 identified the resident with a BIMS score of 15/15, and received ROM active and passive 5 days in the last 7 calendar days for at least 15 minutes a day.

The cognition CAA (care area assessment) dated

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12/8/11 revealed the resident experienced no cognitive loss, was verbally hostile towards staff, and experienced depression. The CAA identified the resident experienced no pain with the last assessment of pain completed by staff on 12/7/11.

The psychosocial well being CAA dated 12/8/11 identified the resident preferred to be alone most of the time, preoccupied with loss of past lifestyle; preferred to be outside smoking or take coffee breaks in the dining room.

The ADL (activities of daily living) CAA dated 12/8/11 revealed the resident displayed almost daily behavioral symptoms, was on celexa and trazadone (medications for depression), experienced physical limitations related to multiple sclerosis, and was wheelchair bound.

The care plan with a review date of 2/29/12 included the following interventions: "limited assist of 1 with dressing upper body, extensive assist with lower body, feeds self with set up help only. Do a pain assessment every 3 months and PRN (as needed), use gentle massage for complaints of BLE (bilateral lower extremity) muscle spasms or cramps, transfers with 1-2 assist and refuses using a gait belt. PT (physical therapy) evaluations every 3 month and PRN for restorative program and encourage the resident to participate in his/her restorative program. [He/she] is refusing his/her restorative program at this time." The care plan lacked a specific individualized restorative program or any alternative interventions to address the resident's refusal.

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Review of the resident's Restorative Flowsheets dated April 2012 revealed the resident received A/PROM (active and passive range of motion) and strength exercises to UE (upper extremities) and LE (lower extremities) 10-15 reps (repetitions) with 5 second hold, 3-7 days/wk (week). The restorative aides signed the resident received these services 4 days each week for two week and 5 days one week in April. Review of the Restorative Flowsheets for the last 3 months revealed the resident only refused one week due to illness during that 3 month period.

On 4/23/12 at 2:40 p.m. observation revealed the resident sat in his/her wheelchair outside on the front porch smoking a cigarette. The resident's feet rested on the wheelchair's foot pedals. The resident used his/her arms without any problems. He/she moved his/her wheelchair forward a couple of times, then locked the wheels of the wheelchair. The resident moved his/her legs with his/her hands and repositioned his/her feet on the foot pedals.

On 4/24/12 at 10:00 a.m. observation revealed the resident participated in group exercise, exercising his/her upper extremities.

Observation on 4/24/12 at 1:15 p.m. revealed direct care staff V provided PROM to the resident's lower extremities. He/She performed 10 reps each working the resident's knees, legs, ankles, and feet joints. The resident willingly participated for about 20 minutes. Then the resident said "we are done."

On 4/23/12 at 2:40 p.m. during an interview, resident #18 reported he/she currently

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participated in a restorative program. He reported the program targeted his/her lower extremities because he/she had no problems with his arms. The resident reported the restorative staff came to his/her room every day around 1:30 p.m. He reported the facility did a good job with the limited resources they had when it came to therapy.

On 4/23/12 at 3:40 p.m. direct care staff U confirmed the resident had a restorative program and he/she worked with the resident daily 5 times a week. Staff U reported the resident had refused for about a week or so because he/she was ill, but was now participating in the program.

On 4/23/12 at 4:45 p.m. direct care staff A reported the resident required assistance of 2 persons with transfers and 1 assist with dressing for bed and toileting. Staff A reported the resident participated in his/her activities of daily living when he/she was able. Staff A reported that the resident's lower extremities were more affected by his/her disease than his/her upper extremities.

On 4/24/12 at 3:50 p.m. nursing staff D confirmed the resident participated in a restorative program. He/she reported he/she was aware that the resident refused at times because of being sick or not feeling well, but to staff D's knowledge the resident still participated on a regular basis.

During an interview on 4/24/12 at 4:20 p.m. administrative nursing staff L reported he/she did not include maintenance restorative programs on residents' care plans. Staff L reported he/she only placed therapy programs on the care plans if

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F 279	Continued From page 18 a resident's discharge plan was to go home. On 4/24/12 at 5:05 p.m. during an interview, administrative staff M revealed he/she expected the care plans to include residents' restorative programs. The facility failed to develop a comprehensive care plan to include the resident's individualized restorative program.	F 279		
F 329 SS=E	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.	F 329		

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This REQUIREMENT is not met as evidenced by:
The facility census totaled 35 residents with 17 residents sampled. Of those, 10 residents were reviewed for unnecessary medications. Based on observation, interview and record review, the facility failed to ensure 9 of 10 sampled residents' medication regimens remained free from unnecessary drugs by the failure to monitor for medications with Black Box Warnings (BBW), a significant adverse effect, failure to follow up after administering PRN (as needed) medications for effectiveness, and the failure to monitor behaviors to ensure the need for psychotropic medications.(#2,# 6, #7, #10, #13, # 16, #22, #33, #37)

Findings included:

- Review of resident # 2's signed physician order sheet dated 4-3-2012 included the following diagnoses: unspecified neurotic disorder, hypertension, encephalopathy, syphilitic brain syndrome, hypothyroidism, hyperlipidemia, anemia, peptic ulcer, bulimia, constipation, nausea / vomiting, obsessive compulsive personality, depressive disorder, internal hemorrhoids, fracture of ankle, and dementia with behavioral disturbance. Review of the admission face sheet revealed an admission date of 12-6-2000.

Review of the resident's most recent annual MDS (minimum data set) with an ARD (assessment reference date of 8-24-2011 revealed a BIMS (brief interview for mental status) score of 15/15, cognitively intact. The MDS revealed the resident

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felt tired or had little energy with no other mood or behavioral symptoms - (physical, verbal, or other behaviors such as hitting, scratching self, resistive to care). It also revealed the resident received antipsychotic, antianxiety and antidepressant medications.

Review of the most current quarterly MDS with an ARD of 2-9-2012 revealed the resident with a BIMS score of 15, cognitively intact without signs of delirium, and no behavioral symptoms. It also revealed the received antipsychotic, antianxiety and antidepressant medications.

Review of the psychotropic medication use CAA dated 8-24-2011 revealed the resident received abillify (antipsychotic), zoloft (antidepressant) and ativan (antianxiety medication). It revealed the resident used the medications to manage diagnoses of obsessive compulsive personality, depressive disorder and dementia with behavioral disturbance. It included the staff should continue to observe for side effects of medication, monthly psychiatric consultant visits to ensure the LED (lowest effective dose).

Review of the care plan dated 2-14-2012 included a problem for risk of decline in strength, Activities of daily living and resident choices. It included interventions to remind and encourage the use of geri-sleeves and theraband gloves to both arms while awake to prevent obsessive picking. It directed staff to remove the geri-sleeves at bed time and change daily but failed to direct staff on the monitoring of the behaviors. The care plan included different medications with common side effects but did not direct staff on the monitoring and reporting of specific behaviors related to the

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ativan, abilify, zoloft and Luvox. The care plan also failed to identify and direct staff to monitor for BBW for the following medications as identified in the "BlackBoxRx.com" web site: Abilify related to increased risk of death, Zoloft regarding the monitoring for clinical worsening, suicidality, or unusual changes in behavior. It also failed to identify Tylenol and Lortab regarding acute liver failure, and not to exceed acetaminophen at doses that exceed 4000 milligrams per day, and compazine regarding risk of death.

Review of the resident's nurses notes dated 2-15-2012 through 4-25-2012 revealed the nursing staff documented behaviors 2 times. The nurses notes dated 3-24-2012 revealed the resident picked at his/her forearm, and told the nurse it did not itch, and was just a "bad habit". The nurses notes dated 3-26-2012 revealed the resident's skin red in color where the resident picked at his/her hand.

Observation on 4-23-2012 at 1:32 p.m. revealed the resident wore a geri-sleeve on his/her right arm, a type of protective covering, with an open sore by his/her thumb.

Observation on 4-23-2012 at 4:14 p.m. revealed the resident did not have geri-sleeve on his/her right arm as care planned and revealed multiple open sores on his/her arm that presented with redness and a small amount of blood on each one.

During an interview on 4-24-2012 at 1:46 p.m. direct care staff C reported staff monitored all of the resident's behaviors. He/she reported behaviors of picking at his/her arm and the

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smearing of bowel movement on things. He/she also reported the resident was resistant to care at times. Direct care staff C reported he/she informed the nurse of any behaviors the resident experienced.

During an interview on 4-24-2012 at 1:59 p.m. direct care staff B reported medication aides did not document behaviors that the nurses were responsible to document. He/she would inform the nurse of any behaviors the resident experienced and the nurses followed up on it.

During an interview on 4-24-2012 at 3:36 p.m. licensed nurse D reported the resident had a psychiatrist that came monthly to see the resident and the nurse was to call the physician if there were any changes in behaviors. He/she also reported there was no specific routine documentation for the monitoring of the behaviors. Licensed nurse D reported he/she just put the behaviors in the 24 hour report book to pass on to the next shift or called the physician if needed.

During an interview on 4-26-2012 at 10:19 a.m. Consultant E confirmed the lack of any behavior monitoring regarding psychotropic medications and confirmed the facility did not identify or monitor the Black Box warning medications on the residents care plan. Consultant E reported the facility received a list of BBW medications from consultant H but he/she did not know what had been done regarding the recommendations after that.

During an interview on 4-26-2012 at 5:10 p.m. consultant H reported he/she gave the facility a

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list of residents and the BBW medication they took that needed to be monitored in January of 2012. Consultant H reported that he/she was not sure where the facility needed to document the monitoring and did not realize the BBW needed to be included in the plan of care. Consultant H reported that he/she did not normally review the care plans with monthly reviews. He/She reported that for the behavior monitoring he/she looked at the nurses notes for documentation of behaviors.

The facility failed to ensure the resident's medication regimen remained free of unnecessary medications by the failure to monitor behaviors and the effectiveness of the medications for behaviors. The facility also failed to monitor for severe adverse effects of medications, BBW.

- Review of resident # 10 undated signed physician order sheet included the following diagnoses: hyperlipidemia, depressive disorder, essential hypertension, ventricular fibrillation and flutter, esophageal efflux, functional digestive disorders, insomnia, constipation, and history of myocardial infarct with an admission date of 12-8-2011.

Review of the admission MDS (minimum data set) with an ARD of 12-19-2011 revealed a BIMS score of 10, moderate cognitive impairment. It revealed the resident did not have any mood or behavior problems.

Review of the CAAS dated 12-20-2011 revealed mood and behavior did not trigger for further assessment.

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F 329	Continued From page 24 Review of the care plan dated 3-20-2012 failed to identify Remeron, Zoloft and tylenol extra strength as medications with black box warnings and the need for special monitoring due to possible severe adverse effects. According to BlackBoxRX.com, Remeron and Zoloft have a BBW regarding monitoring appropriately and observed closely for clinical worsening, suicidality, or unusual changes in behavior. Tylenol (acetaminophen) has a BBW regarding acute liver failure and not to exceed 4000 milligrams per day including acetaminophen-containing products. Review of the medication administration record (MAR) revealed the resident received ambien on 1-3-2012 for insomnia and 1-4-2012 for restlessness without any follow up regarding effectiveness of the medication. Review of the MAR for February 2012 revealed the resident received tylenol 325 mg (milligrams) 2 tablets for general discomfort on 2-9-2012 with no follow up for effectiveness, and again on 2-15-2012 received tylenol for back pain with no follow up for effectiveness. Observation on 4-24-12 at 7:48 a.m. revealed the resident walked independently using a front wheeled walker. Observation revealed the resident walked down the hall a couple of times the resident had to pick up the walker because he/she steered it into the wall. During an interview at 1:46 p.m. on 4-24-2012 direct care staff C reported the nurses	F 329		

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F 329	Continued From page 25 documented the resident behaviors. During an interview on 4-24-2012 at 3:36 p.m. licensed nurse D reported the resident had a psychiatrist that came monthly to see the resident and the nurse was to call the physician if there were any changes in behaviors. He/she also reported there was no specific routine documentation for the monitoring of the behaviors. Licensed nurse D reported he/she just put the behaviors in the 24 hour report book to pass on to the next shift or called the physician if needed. During an interview on 4-26-2012 at 10:19 a.m. Consultant E confirmed the lack of any behavior monitoring regarding psychotropic medications and confirmed the facility did not identify or monitor the Black Box warning medications on the residents care plan. Consultant E reported the facility received a list of BBW medications from consultant H but he/she did not know what had been done regarding the recommendations after that. During an interview on 4-26-2012 at 5:10 p.m. consultant H reported he/she gave the facility a list of residents and the BBW medication they took that needed to be monitored in January of 2012. Consultant H reported that he/she was not sure where the facility needed to document the monitoring and did not realize the BBW needed to be included in the plan of care. Consultant H reported that he/she did not normally review the care plans with monthly reviews. He/She reported that for the behavior monitoring he/she looked at the nurses notes for documentation of behaviors.	F 329		

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During an interview on 4-30-2012 at 3:00 p.m. administrative nurse M reported his/her expectation was for staff to follow up on prn medications that had been administered within an hour and document the findings as to the effectiveness of the medications.

The facility failed to ensure the resident's medication regimen remained free of unnecessary medications by the failure to monitor behaviors and the effectiveness of the medications for behaviors and the failure to monitor for severe adverse effects of medications regarding BBW.

- Review of resident # 22's signed physician order sheet dated 4-4-12 included the following diagnoses: dementia with behavioral disturbance, anal fistula, renal failure, hepatitis-C, diabetes, hypertension, calculus of kidney, atherosclerosis, chronic kidney disease,, spinal stenosis of lumbar region, cardiac dysrhythmia, thrombocytopenia, anemia, depressive disorder with a current admit date of 3-16-2010.

Review of the most recent annual MDS (minimum data set) with an ARD (assessment reference date) of 2-15-2012 revealed a BIMS (brief interview for mental status score) of 9, moderate cognitive impairment. It also revealed mood, behaviors, and psychotropic medications did not trigger for further investigation.

Review of the medication administration record for the month of April revealed the resident received atenolol 25 mg (milligrams) daily for hypertension, lasix 20 mg daily for hypertension

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F 329	Continued From page 27 and Lortab 5/500 three times a day for pain management. Review of the care plan dated 2-21-2012 lacked evidence of identifying atenolol, lasix or the lortab as having a BBW and the need for monitoring. According to BlackBoxRx.com Atenolol has a BBW not to discontinue abruptly; Lasix has a BBW that it can lead to profound diuresis,resulting in fluid and electrolyte depletion and Lotrab is a combination medication with acetaminophen which has a black box warning regarding acute liver failure and not to exceed 4 grams in 24 hours. Observation on 4-24-12 at 9:55 am revealed the resident sat in recliner chair reading newspaper, call light within reach. Observation on 4-26-2012 at 9:46 a.m. resident sat in recliner working with restorative aide using the pulleys for upper extremity strengthening. During an interview on 4-24-2012 at 3:36 p.m. licensed nurse D reported the resident had a psychiatrist that came monthly to see the resident and the nurse was to call the physician if there were any changes in behaviors. During an interview on 4-26-2012 at 10:19 a.m. Consultant E confirmed the facility did not identify and monitor the Black Box warning medications on the care plan. Consultant E reported the facility received a list of BBW medications from the Consultant but did not know what had been regarding the recommendations after that.	F 329		

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During an interview on 4-26-2012 at 5:10 p.m. consultant H reported he/she gave the facility a list of residents and the BBW medication they took that need to be monitored in January of 2012. Consultant H reported that he/she was not sure where they needed to document the monitoring and did not realize the BBW needed to be included in the plan of care. Consultant H reported that he/she did not normally review the care plan with monthly reviews. Consultant H reported that he/she did not assist the facility in developing a system for the monitoring of BBW med's.

The facility failed to ensure the resident's medication regimen remained free of unnecessary medications by the failure to monitor for severe adverse effects of medications for resident # 22.

- Review of resident #37's signed physician's orders dated 4/4/12 revealed the following diagnoses: presenile dementia, dementia with behavioral disturbances, closed fracture of acetabulum, closed fracture of acromial end of clavicle, cardiac pacemaker, low body weight, dementia with psychosis and behaviors, depression, pain and constipation.

Review of the most recent quarterly MDS (minimum data set) dated 3/21/12 identified the resident with a BIMS (brief interview of mental status) score of 0 (severe cognition deficit), experienced inattention, disorganized thinking, hallucinations and delusions. The MDS also identified the resident required extensive assist of 2 persons with bed mobility, transfer, walking in

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room and corridor, dressing toilet use and personal hygiene. The MDS revealed the resident also required limited assistance of one person with eating.

Review of the admission MDS dated 12/21/11 identified the resident with a BIMS score of 2 (severe cognition deficit), experienced inattention and disorganized thinking, hallucinations and delusions. The MDS also identified the resident required extensive assist of 2 persons for bed mobility, transfer, walking in room and corridor, toilet use, and dressing and limited assist of one for personal hygiene. experienced mild pain.

Review of the cognitive CAA (care area assessment) dated 12/21/11 further assessed the resident with anxiety/agitation and behavioral disturbances, poor nutrition low weight of 115 pounds. The CAA also identified the resident experienced a short attention span, confusion, forgetfulness and disorientation. It identified the resident lived in the past through hallucinations and delusions.

The care plan dated 12/27/11 included monitoring for common ADR (adverse drug reactions) of Seroquel which included: anticholinergic effects, akasthesis, neuroleptic malignant syndrome, cardiac arrhythmia, heart failure, falls and lethargy, but failed to include the black box warning (serious or life-threatening adverse side effects) of elderly patients with dementia-related psychosis treated with a typical or conventional antipyretics are at increased risk for death and the need to monitor electrolytes.

The resident's care plan dated 12/27/11 included

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a revision date of 2/16/12 for staff to monitor for common adverse drug reactions for zoloft (a medication used to treat depression) which included observe and report insomnia, somnolence, dizzy, headache, tremors, fatigue, seizures, malignant syndrome like reaction, nausea and vomiting, anorexia, constipation or diarrhea. The care plan failed to include the black box warning for clinical worsening of suicidal thinking or changes in behavior.

Review of the Pharmacy Report dated 1/25/12 revealed consultant H provided the facility with a list of residents who received medications with a BBW (black box warning) and what the staff needed to monitor regarding each drug listed. Consultant H informed the facility of the need for monitoring of the BBW for Seroquel which Consultant H included, suicidal thinking and electrolytes. The facility failed to include the monitoring for suicidal thinking and electrolytes on the resident's plan of care.

On 4/24/12 at 4:15 p.m. administrative nursing staff L confirmed he/she did not include BBWs on the plan of care.

On 4/24/12 at 5:10 p.m. administrative nursing staff M reported he/she was unaware that BBW's were to be care planned. He/She stated consultant H told the facility about 2 months ago they had to document BBWs on the nurses' notes.

On 4/26/12 at 3:00 p.m. consultant E reported the facility was working on a behavioral monitoring and BBW systems but was not in operation at this time.

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F 329	Continued From page 31 On 4/26/12 at 5:10 p.m. interview with consultant H revealed he/she had notified the facility of the need to monitor for black box warnings by providing the facility with a list of residents and their medications that had a BBW in January 2012. Consultant H reported he/she was unaware that the black box warnings needed to be included in the plan of care or what else he/she was to do with the BBWs. Consultant H reported he/she did not review care plans during his/her monthly reviews. He/She confirmed he/she had not done anything further with BBWs. Consultant H reported he/she did not assist the facility in developing any system or policies regarding black box warnings. The facility provided no policy regarding the monitoring of black box warnings. The facility failed to have a monitoring system in place for BBWs for the resident to effectively monitor for potential serious and/or life threatening side effects of Seroquel and Zoloft for this resident. - Review of resident #7's signed Physician's Order Sheet (POS) and dated 4-1-2012 revealed the resident with the following medical diagnoses: depressive disorder, osteoarthrosis, major depressive affective disorder, senile demential with delusional or depressive features, osteoporosis, and psychosis. Review of the annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 10-20-11 identified the resident with a BIMS	F 329		

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score of 12, moderate cognitive impairment. He/she experienced disorganized or incoherent, unclear or illogical flow of ideas, or unpredictable switching from subject to subject. The resident did not have mood problems or behaviors.

Review of the resident's cognitive loss/dementia Care Assessment Area (CAA's) dated 10-10-11 revealed he/she had no negative moods or behaviors.

Review of the resident's psychotropic medication use CAA dated 10-10-11 revealed he/she was doing well with reduction of the abilify dose and had no signs or symptoms of adverse reactions from the remeron, effexor, and abilify.

The resident's care plan dated 10-20-11, updated 1-24-12 and 4-24-12, directed staff to report hallucinations or delusions to the nurse, attempt to discover possible underlying cause of hallucinations or delusions, and provide an assessment for physical complaints. It also directed staff to monitor for an increase in negative behaviors and anxiety.

Review of the resident's pharmacy consult notes dated 1-25-12 identified Black Box Warning (BBW) for aripirrazole, mirtazapine, and venlafaxine regarding increased risk for suicidal thinking and death but the resident's plan of care lacked BBW for these medications.

Review of the psychiatric consultation record dated 3-23-12 revealed no new concerns or behaviors. The record indicated resident #7 diagnosed with depression, senile dementia with delusions, and psychosis. The resident

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determined to be oriented to person, mood congruent, affect as flamboyant, thought process as goal directed, though content concrete, attention span normal, insight fair, and judgement limited.

Review of the resident's Medication Administration Record (MAR) revealed lortab administered as needed for pain 13 times during March 2012 and 10 times from 4-2-12 through 4-23-12 but staff failed to document the effectiveness on the MAR.

Observation on 4-24-12 at 10:13 am revealed resident #7 at the sink brushing his/her teeth. The resident propels him/her self in the room without difficulty.

Observation on 4-26-12 at 9:35 am revealed the resident participated in the "get fit activity".

An interview on 4-26-12 at 2:50 pm with administrative nursing staff L confirmed the resident's care plan lacked interventions for monitoring black box warnings.

An interview on 4-26-12 at 3:00 PM with Consultant E confirmed resident's plan of care lacked monitoring for BBW.

An interview on 4-30-12 at 3:00 PM with administrative nursing staff M reported the expectation of staff was to follow up on administered as needed medications within an hour of providing and to document the effectiveness of the medications.

An interview on 4-30-12 at 4:00 PM with licensed

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nursing staff T revealed he/she often did not document the effectiveness of the lortab. Staff T indicated he/she was aware it needed to be done but did not have time.

The facility did not provide a policy for administration of as needed medications or black box warnings.

Review of the facilities Administering Pain Medications policy dated 2/01/2005 revealed the policy lacked direction for the documentation on the effectiveness of as needed pain medications.

The facility failed to adequately assess and monitor the effectiveness of medications and failed to monitor the black box warnings for possible serious side effects.

- Review of resident #33's signed Physicians's Order Sheet and dated 4-1-12 revealed the resident with the following diagnoses: hypothyroidism, diabetes mellitus, and depressive disorder.

The MDS dated 3-14-2012 indentified the resident with a BIMS score 00 on a scale of 00-15, experienced an acute onset of mental status changes and received an antidepressant. The assessment also revealed he/she required the assist of one person for most activities of daily living and was not steady with transfers or position changes.

Review of the resident's Fall Risk CAA revealed the resident had experienced falls dated 1-6-12 at 8:10 am and 1-14-12 at 8:00 am. Staff identified the resident as unsteady on his/her feet

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and had trouble maintaining standing positions. The CAA indicated the resident needed a pad or personal alarm and required one person assist with ambulation and walker. Staff were to provide the resident monthly two way blood pressures and perform a fall assessment every three months or as needed.

Review of the resident's Psychotropic Risk CAA revealed the resident received Remeron and Paxil for depression and appetitive stimulant. The CAA indicated the resident did experienced delirium but the psychotropic medications were not assessed to be the likely cause.

Review of resident #33 care plan dated 3-16-2012 revealed he/she experienced problems with falls, poor balance, impulsivity, drop in blood pressure with position changes and at high risk for falls. The care plan revealed the resident needed one person assist for bed mobility, personal hygiene, toileting, ambulating, and dressing.

Review of care plan updated 4-2-12 directed staff to discontinue paxil and initiate xanax as needed for anxiety and restlessness. The update instructed staff to monitor and report possible side effects including dizziness, drowsiness, orthostatic hypotension, tachycardia, blurred vision, and rash.

Review of care plan updated 4-17-12 instructed staff to initiate luvox and to observe and report side effects including headache, drowsiness, dizziness, seizures, neurological malignant syndrome, rash, sweating, nausea or vomiting, constipation, diarrhea, and hepatotoxicity. The

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F 329	Continued From page 36 care plan lacked black box warning for suicidal thinking. Review of the resident's care plan revealed the staff failed to include and monitor black box warnings for metformin related to lactose acidosis and tylenol not to exceed 4 grams daily and monitor for hepatotoxicity.. Review of the resident's MAR dated 4 1-12 through 4-26-12 revealed he/she received Xanax 28 times but staff failed to document the effectivieness on back of the MAR 10 times. Observation on 4-23-12 at 4:22 pm revealed the resident sleeping quietly in bed. Observation on 4-24-12 at 1:21 pm revealed the resident sat in the wheelchair and propelled self down the hall. Observation on 4-26-12 at 12:00 pm revealed the resident up in recliner. The resident is yelling out "help, help, help" and staff responded and attempted to calm the resident by offering a drink, providing 1 on 1, and repositioned him/her into the wheelchair. Interview on 4-23-12 with direct care staff K at 4:18 pm revealed he/she would go to the charge nurse, director of nursing, or look in the care plan when seeking information on how to care for resident. Interview on 4-26-12 with administrative nursing staff L at 2:50 pm reported the resident's care plan lacked monitoring for black box warnings.	F 329		

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Interview on 4-26-12 with licensed Consultant E at 3:00 PM confirmed the resident's care plan lacked monitoring for black box warnings.

During a telephone interview on 4-30-12 with administrative nursing staff M at 3:00 PM reported the expectation of staff was to follow up on as needed medications within one hour of administration and document the effectiveness of the medications.

The facility failed to adequately assess and monitor the effectiveness of as needed medications and failed to monitor for black box warnings for possible serious side effects.

- Review of resident # 6's signed physician orders dated 4/10/12 revealed the following diagnoses: acute onset of chronic respiratory failure congestive heart failure, stage 4 sarcoidosis/fibrosis, hypertension, depression, allergies, broncho spasms, insomnia, hypothyroidism, constipation, esophageal reflux disease, hemorrhoids.

The review of the significant change MDS (minimum data set) with an ARD (assessment reference date) of 4/19/12 revealed a BIMS (brief interview for mental status) of 14 (cognitively intact). The medication section of the MDS revealed a use of antidepressant and antianxiety medications.

The psychotropic drug use CAA (care area assessment) dated 4/19/12 revealed the resident took Lorazepam and Celexa. The resident had chronic years of Lorazepam use with previous unsuccessful attempts to stop the medication.

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Review of the care plan dated 2/6/12 included common side effects for Celexa (antidepressant) and APAP (Acetaminophen) but lacked interventions for monitoring and reporting of specific or severe side effects of BBW (black box warning) medications. The care plan failed to identify common and severe side effects for Lasix. According to" BlackBoxRx.com" website Celexa has BBW regarding for clinical worsening suicdality or unusual changes in behavior, Acetaminophen, regarding acute liver failure and not to exceed a maximum dose of 4000 mg (milligrams) in 24 hours, Lasix lead to profound diuresis with water and electrolyte depletion.

Review of the medication administration sheets revealed that the facility did not follow up for responses for the PRN of the given PRN (as needed) medications administered on the following dates of the following medications:

Mylanta on 1/24/12, 3/10, 3/11, 3/12, 3/26/12

Ambien on 4/10/12

Ducolax on 2/13, 2/26/12

Lorazepam on 1/26, 3/14, 3/16, 3/17, 3/26/12

Tylenol on 1/26, 3/14, 3/21, 3/24/12

On 4/24/12 at 10:00 a.m. observation revealed the resident smiled and talked softly to direct staff U. The resident did not avoid eye contact when talking.

On 4/26/12 at 12:10 p.m. observation revealed

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F 329	Continued From page 39 the resident smiled at staff member V, who assisted the resident in the dining room. During an interview on 4/26/12 at 10:19 a.m., Consultant E confirmed the facility did not identify and monitor for BBW medications on the residents' plan of care. Consultant E confirmed the facility received a list of BBW medications from the pharmacist on 1/25/2012 but did not know what happened to them after that. On 4/26/12 at 11:05 a.m., licensed nursing staff T reported that he/she had worked with the physician to get the pain medications reduced and changed around to work better. Staff T stated that staff was to chart the PRN's (as needed) and their effectiveness on the PRN sheet. On 4/26/12 at 5:10 p.m., an interview with consultant H revealed he/she provided the facility a list of resident # 6's Black Box Warnings for Celexa and Lasix dated 1/25/12. He/she reported that he/she was not sure where that needed to be documented. Consultant H reported he/she did not realize the BBW needed to be included in the care plan. Consultant H reported that he/she did not normally review the care plan with monthly reviews and did not assist the facility in developing a system for the monitoring of BBW medications. During an interview with Administrative staff M on 4/30/12 at 3:00 p.m. he/she reported that the expectation was for staff to follow up on the PRN (as needed) medications that had been administered within 1 hour and document the effectiveness of the medication.	F 329		

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The facility failed to provide a policy on the monitoring of the BBW's and the PRN medications.

The facility failed to ensure the resident's medication regime remained free of unnecessary medications by failure to monitor the effectiveness of the PRN medication to ensure the need for the medication. The facility failed to monitor the severe adverse reactions of the medications with BWW, to ensure the identification of any adverse side effects so the physician could determine if the benefits of the medication outweigh the side effects.

- The Review of resident # 16's signed physician orders dated 3/4/12 revealed the following diagnoses: chronic obstructive pulmonary disease, restless leg syndrome, coronary artery disease, diabetes mellitus, hypertension, gastro-esophageal reflux disease, fibromyalgia, and osteopenia.

Review of the significant change MDS (minimum data set) with an ARD (assessment reference date) of 4/18/12 revealed that the resident experienced mood problems. The resident had little interest, or pleasure in doing things 2-6 days, feeling down for 2-6 days, trouble falling asleep or staying asleep or sleeping to much 7-11 days during the 14 day look back period. The resident reported being tired with little energy 2-6 days; poor appetite/overeating 12-14 days during the 14 day look back period. He/she also had trouble concentrating and feeling bad about his/herself 2-6 days of the look back period of 14 days.
The psychosocial well- being CAA (care area assessment) dated 4/19/12 identified the resident

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experienced behavior problems prior to admission to the facility.

Review of the care plan dated 4/25/12 revealed Effexor and Lasix was care planned for common side effects; but failed to identify and direct staff to monitor for BBW for the following medications Effexor, Metoprolol, and Lasix. According to "BlackBoxRx.com" for Metoprolol not to discontinue abruptly due to cardiac risk, and Lasix, may lead to profound diuresis with water and electrolyte depletion if given in excessive amounts. Effexor not to discontinue the medication abruptly the dose should be tapered over a 2 week period of time.

Review of the medication administration sheets dated April 2012 indicated the staff failed to follow up of the given PRN (as needed) medications done for the following dates and the following medications:

Oxycodone on 2/5, 2/22 times 2, 2/25, 2/28, 2/29, 3/1, 3/2, 3/5, 3/8/ 3/10, 3/11, 3/13, 3/14, 3/24, 3/30, 3/31, 4/1 times 2, 4/3, 4/6, 4/7, 4/8, 4/10, 4/12, 4/14/12.

Maalox on 3/6/12.

Tylenol on 2/12 times 2, 2/20 x's 2, 2/22, 2/25, 2/27, 2/28, 3/4, 3/4, 3/18/12

Tordol on 3/10, 3/11, 3/15, 3/18/12

Ibuprophen on 3/11, 3/12, 3/15, 3/20, 3/18, 3/20, 3/24, 3/26, 4/2, 4/8, 4/10, 4/20 times 2, 4/21, 4/22, 4/23 times 2, 4/24/ times 2, 4/25 times 2, 4/26/12

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Miralax on 2/1, 2/2, 2/5, 2/7, 2/9, 2/26, 3/3, 3/15, 3/18, 4/12, 4/13, 4/15, 4/17/12.

On 4/24/12 at 11:45 a.m. observation revealed the resident finished the care plan meeting and sat in his/her room crying.

On 4/26/12 at 10:30 a.m.,observation revealed the resident visited freely with his/her roommate and without behaviors noted.

During an interview on 4/26/12 at 10:19 a.m., Consultant E confirmed the facility did not identify and monitor for BBW medications on the residents' plan of care. Consultant E confirmed the facility received a list of BBW medications from the pharmacist on 1/25/2012 but did not know what happened to them after that.

On 4/26/12 at 11:05 a.m., licensed nursing staff T reported that he/she had worked with the physician to get the pain medications reduced and changed around to. Staff T stated that staff was to chart the PRN's (as needed) and their effectiveness on the PRN sheet.

On 4/26/12 at 5:10 p.m., an interview with consultant H revealed he/she provided the facility a list of resident #16's Black Box Warnings for Effexor, Metoprolol and Lasix dated 1/25/12. He/she reported that he/she was not sure where it needed to be documented in the record. Consultant H reported he/she did not realize the BBW needed to be included in the care plan. Consultant H reported that he/she did not normally review the care plan with monthly reviews and did not assist the facility in

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F 329	Continued From page 43 developing a system for the monitoring of BBW medications. During an interview with Administrative staff M on 4/30/12 at 3:00 p.m. he/she reported that the expectation was for staff to follow up on the PRN (as needed) medications that had been administered within 1 hour and document the effectiveness of the medication. The facility failed to provide a policy on the monitoring of the BBW's and the PRN medications. The facility failed to ensure the resident's medication regime remained free of unnecessary medications by failure to monitor the effectiveness of the PRN medication to ensure the need for the medication. The facility failed to monitor the severe adverse reactions of the medications with BWW, to ensure the identification of any adverse side effects so the physician could determine if the benefits of the medication outweigh the side effects. - The Review of resident #13's signed physician orders dated 3/20/12 revealed the following diagnoses; diabetes mellitus with out of complications type 2, chronic obstructive asthma, diabetic renal complications, depressive disorder, nephritis and nephropathy lesion in the kidney, chronic kidney disease, exocytosis of nasal mucosa chest pain personal history of urinary tract infection multiple, congestive heart failure, traumatic amputation of the right leg, constipation, neurological manifestations from diabetes, morbid obesity, essential hypertension, osteoarthritis, generalized atherosclerosis, old	F 329		

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myocardial infarction, with stent, angioplasty hyperlipidemia esophageal reflux disease.

Review of the annual MDS (minimum data set) with an ARD (assessment reference date) of 12/15/11 and a BIMS (brief interview of mental status) score of 15 indicating the resident is cognitively intact. Overall presents of behavioral symptoms indicate the resident has had the following verbal and behavioral symptoms directed toward others

Review of the cognative/loss CAA (care area assessment) dated 3/22/12 revealed the residents cognitive status was intact though the resident had negative behaviors

Review of the care plan dated 1/17/12 care planned the more common side effects of Celexa but failed to identify the more serious BBW (black box warning) for Celexa and Bumex. According to "BlackBoxRx.com" website Celexa has BBW regarding for clinical worsening sociality or unusual changes in behavior. Bumex related to the monitoring of the serum electrolyte, creatinine and BUN.

Review of the medication administration sheets indicate that no follow up of given PRNs on the following dated of the following medications:

Mylanta on 1/15, 1/18 x's 2, 3/10, 3/12, 3/14/12 on the PRN sheet

Tusselon Perles on 4/24, 4/25 x's2, 4/26 x's 2 on the PRN sheet

Musinex on 4/24, 4/26/12 on the PRN sheet

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F 329	Continued From page 45 Sildec on 3/24 x's 2, 3/25, 3/26, 3/27, 3/28 x's 2 3/29 x's 3, 3/30 x's 2, 3/31 x's 3 on the PRN sheet. Milk of Magnesia on 3/10, 3/15/12 Ducolax Suppository on 2/1, 2/11, 3/10, 3/16/12 Tylenol on 3/10/12 Lortab on 1/2, 1/3, 1/15, 2/5, 2/12 x's 2 2/13, 2/17, 2/22 x's 2, 2/24, 2/26, 2/29, 3/1, 3/2, 3/4, 3/5, 3/7, 3/8, 3/9, 3/10 x's 2, 3/11, 3/12, 3/13, 3/14, 3/15, 3/16, 3/18, 3/20, 3/21, 3/23, 3/24 x's 2, 3/25 x's 4, 3/26, 3/28, 4/19 x's 2, 4/21, 4/22 x's 2, 4/24/12 On 4/23/12 at 2:00 p.m. observation made of the resident sitting in the living room in a large recliner watching television. Resident interacted with both the residents and the staff, resident smiled. On 4/23/12 at 3:15 p.m. observation of the resident revealed her frowning and yelling, and accused staff of wrong doings. Resident blamed the staff for not leaving his/her with the call light earlier but the staff were still in the room with his/her at the time. During an interview on 4/26/12 at 10:19 a.m., Consultant E confirmed the facility did not identify and monitor for BBW medications on the residents' care plan. Consultant E confirmed the facility received a list of BBW medications from the pharmacist on 1/25/2012 but did not know what happened to them after that.	F 329		

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On 4/26/12 at 11:05 a.m., licensed nursing staff T had reported that he/she had worked with the physician to get the pain medications reduced and changed around. Staff T stated that staff was to chart the PRN's (as needed) on the PRN sheet and then chart the effectiveness of the medication.

On 4/26/12 at 5:10 p.m., an interview with consultant H revealed he/she provided the facility a list of resident #13's Black Box Warnings for Celexa and Bumex dated 1/25/12. He/she reported that he/she was not sure where that needed documenting. Consultant H reported he/she did not realize the BBW needed to be included in the care plan. Consultant H reported that he/she did not normally review the care plan with monthly reviews and did not assist the facility in developing a system for the monitoring of BBW medications.

The facility failed to provide a policy on the monitoring of the BBW's and the PRN medications.

During an interview with Administrative staff M on 4/30/12 at 3:00 p.m. he/she reported that the expectation was for staff to follow up on the PRN (as needed) medications that had been administered within 1 hour and document the effectiveness of the medication.

The facility failed to ensure the resident's medication regime remained free of unnecessary medications by failure to monitor the effectiveness of the PRN medication to ensure the need for the medication. The facility failed to monitor the severe adverse reactions of the

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F 329	Continued From page 47 medications with BWW, to ensure the identification of any adverse side effects so the physician could determine if the benefits of the medication outweigh the side effects.	F 329		
F 425 SS=E	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: The facility census totaled 35 residents. The facility reported all 35 residents received medications. Based on interview and record review the pharmacist failed to develop and implement an on going system to identify and monitor for black box warnings (serious and/or life threatening side effects of medications with a	F 425		

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BBW (black box warning). This deficient practice had the potential to affect all 35 residents who received medications.

Findings included:

- Review of the Pharmacy Report dated 1/25/12 revealed consultant H provided the facility with a list of residents who received medications with a BBW (black box warning) and what the staff needed to monitor regarding each drug listed. Review of the Pharmacy Reports from February through March 2012 lacked any further identification or follow-up with monitoring of BBWs.

On 4/24/12 at 4:15 p.m. administrative nursing staff L confirmed he/she did not include BBWs on the plan of care.

On 4/24/12 at 5:10 p.m. administrative nursing staff M reported he/she was unaware that BBW's needed to be included in the plan of care. He/She stated consultant H told the facility about 2 months ago they had to document BBWs on the nurses' notes.

On 4/26/12 at 3:00 p.m. consultant E reported the facility was working on a BBW system but it was not in operation at this time.

On 4/26/12 at 5:10 p.m. interview with consultant H revealed he/she had notified the facility of the need to monitor for black box warnings by providing the facility with a list of residents and their medications that had a BBW in January 2012. Consultant H reported he/she was unaware that the black box warnings needed to

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F 425	Continued From page 49 be included in the plan of care or what else he/she was to do with the BBWs. Consultant H reported he/she did not review care plans during his/her monthly reviews. Consultant H confirmed he/she had not done anything further with BBWs. Consultant H reported he/she did not assist the facility in developing any system or policy's regarding black box warnings. The facility provided no policy or procedure regarding the monitoring of black box warnings. The facility pharmacist failed to develop and implement a system to monitor for BBW. This deficient practice had the potential to affect all 35 residents who received medications.	F 425		
F 428 SS=E	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: The facility census totaled 35 residents with 17 residents sampled. Of those, 10 residents were reviewed for unnecessary medications. Based on observation, interview, and record review the facility failed to follow the pharmacist	F 428		

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recommendations regarding the need to monitor medications with a Black Box Warning (BBW) for 9 or 10 residents. The pharmacist failed to report irregularities regarding the follow up of PRN (as needed) medications for 6 of 10 residents and failed to identify irregularities regarding the monitoring of behaviors for 1 or 10 residents. (#2,# 6, #7, #10, #13, # 16, #22, #33, #37)

Findings included:

- Review of resident # 2's signed physician order sheet dated 4-3-2012 included the following diagnoses: unspecified neurotic disorder, hypertension, encephalopathy, syphilitic brain syndrome, hypothyroidism, hyperlipidemia, anemia, peptic ulcer, bulimia, constipation, nausea / vomiting, obsessive compulsive personality, depressive disorder, internal hemorrhoids, fracture of ankle, and dementia with behavioral disturbance. Review of the admission face sheet revealed an admission date of 12-6-2000.

Review of the resident's most recent annual MDS (minimum data set) with an ARD (assessment reference date of 8-24-2011 revealed a BIMS (brief interview for mental status) score of 15/15, cognitively intact. The MDS revealed the resident felt tired or had little energy with no other mood or behavioral symptoms - (physical, verbal, or other behaviors such as hitting, scratching self, resistive to care). It also revealed the resident received antipsychotic, antianxiety and antidepressant medications.

Review of the most current quarterly MDS with an ARD of 2-9-2012 revealed the resident with a

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BIMS score of 15, cognitively intact with no behavioral symptoms received antipsychotic, antianxiety and antidepressant medications.

Review of the psychotropic medication use CAA dated 8-24-2011 revealed the resident received abillify (antipsychotic), zoloft (antidepressant) and ativan (antianxiety medication). It revealed the resident used the medications to manage diagnoses of obsessive compulsive personality, depressive disorder and dementia with behavioral disturbance. It included the staff should continue to observe for side effects of medication, and monthly psychiatric consultant visits to ensure the LED (lowest effective dose).

Review of the care plan dated 2-14-2012 included a problem for risk of decline in strength, Activities of daily living and resident choices. It included interventions to remind and encourage the use of geri-sleeves and theraband gloves to both arms while awake to prevent obsessive picking. It directed staff to remove the geri-sleeves at bed time and change daily but failed to direct staff on the monitoring of the behaviors. The care plan included common side effects of different medications but did not direct staff on the monitoring and reporting of specific behaviors associated with the administration of ativan, abilify, zoloft and Luvox. The care plan also failed to identify and direct staff to monitor for BBW (a severe potentially life threatening adverse side effect) for the following medications as identified in the "BlackBoxRx.com" web site: Abilify related to increased risk of death, Zoloft regarding the monitoring for clinical worsening, suicidality, or unusual changes in behavior. It also failed to identify Tylenol and Lortab regarding acute liver

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failure, and not to exceed acetaminophen at doses that exceed 4000 milligrams per day, and compazine regarding risk of death.

Review of the resident's nurses notes dated 2-15-2012 through 4-25-2012 revealed the nursing staff documented behaviors 2 times. The nurses notes dated 3-24-2012 revealed the resident picked at his/her forearm, and told the nurse it did not itch, and was just a "bad habit". The nurses notes dated 3-26-2012 revealed the resident's skin was red in color where the resident had picked at his/her hand.

Observation on 4-23-2012 at 1:32 p.m. revealed the resident wore a geri-sleeve on his/her right arm, a type of protective covering, with an open sore by his/her thumb.

Observation on 4-23-2012 at 4:14 p.m. revealed the resident did not have geri-sleeve on his/her right arm as care planned and revealed multiple open sores on his/her arm that presented with redness and a small amount of blood on each one.

During an interview on 4-24-2012 at 1:46 p.m. direct care staff C reported staff monitored all of the resident's behaviors. He/she reported behaviors of picking at his/her arm and the smearing of bowel movement on things. He/she also reported the resident was resistant to care at times. Direct care staff C reported he/she informed the nurse of any behaviors the resident experienced.

During an interview on 4-24-2012 at 1:59 p.m. direct care staff B reported medication aides did

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not document behaviors that the nurses were responsible to document. He/she would inform the nurse of any behaviors the resident experienced and the nurses followed up on it.

During an interview on 4-24-2012 at 3:36 p.m. licensed nurse D reported the resident had a psychiatrist that came monthly to see the resident and the nurse was to call the physician if there were any changes in behaviors. He/she also reported there was no specific routine documentation for the monitoring of the behaviors. Licensed nurse D reported he/she just put the behaviors in the 24 hour report book to pass on to the next shift or called the physician if needed.

During an interview on 4-26-2012 at 10:19 a.m. Consultant E confirmed the lack of any behavior monitoring regarding psychotropic medications and confirmed the facility did not identify or monitor the Black Box warning medications on the residents care plan. Consultant E reported the facility received a list of BBW medications from consultant H but he/she did not know what had been done regarding the recommendations after that.

During an interview on 4-26-2012 at 5:10 p.m. consultant H reported he/she gave the facility a list of residents and the BBW medication they took that needed to be monitored in January of 2012. Consultant H reported that he/she was not sure where the facility needed to document the monitoring and did not realize the BBW needed to be included in the plan of care. Consultant H reported that he/she did not normally review the care plans with monthly reviews. He/She

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reported that for the behavior monitoring he/she looked at the nurses notes for documentation of behaviors.

The Pharmacist failed to identify irregularities regarding the monitoring of behavior management and the effectiveness of medication associated with psychotropic medications. The facility also failed to act upon the pharmacist recommendation regarding the need to monitor medications with Black Box Warnings for resident #2.

- Review of resident # 10 undated signed physician order sheet included the following diagnoses: hyperlipidemia, depressive disorder, essential hypertension, ventricular fibrillation and flutter, esophageal efflux, functional digestive disorders, insomnia, constipation, and history of myocardial infarct with an admission date of 12-8-2011.

Review of the admission MDS (minimum data set) with an ARD of 12-19-2011 revealed a BIMS score of 10, moderate cognitive impairment. It revealed the resident did not have any mood or behavior problems.

Review of the CAA'S dated 12-20-2011 revealed mood and behavior did not trigger for further assessment.

Review of the care plan dated 3-20-2012 failed to identify Remeron, Zoloft and Tylenol extra strength as medications with black box warnings and the need for special monitoring due to possible severe adverse effects.

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According to BlackBoxRX.com, Remeron and Zoloft have a BBW regarding monitoring appropriately and observed closely for clinical worsening, suicidality, or unusual changes in behavior. Tylenol (acetaminophen) has a BBW regarding acute liver failure and not to exceed 4000 milligrams per day including acetaminophen-containing products.

Review of the medication administration record (MAR) revealed the resident received ambien on 1-3-2012 for insomnia and 1-4-2012 for restlessness without any follow up regarding effectiveness of the medication.

Review of the MAR for February 2012 revealed the resident received tylenol 325 mg (milligrams) 2 tablets for general discomfort on 2-9-2012 with no follow up for effectiveness, and again on 2-15-2012 received tylenol for back pain with no follow up for effectiveness.

Observation on 4-24-12 at 7:48 a.m. revealed the resident walked independently using a front wheeled walker. Observation revealed the resident walked down the hall a couple of times the resident had to pick up the walker because he/she steered it into the wall.

During an interview at 1:46 p.m. on 4-24-2012 direct care staff C reported the nurses documented the resident behaviors.

During an interview on 4-24-2012 at 3:36 p.m. licensed nurse D reported the resident had a psychiatrist that came monthly to see the resident and the nurse was to call the physician if there were any changes in behaviors. He/she also

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reported there was no specific routine documentation for the monitoring of the behaviors. Licensed nurse D reported he/she just put the behaviors in the 24 hour report book to pass on to the next shift or called the physician if needed.

During an interview on 4-26-2012 at 10:19 a.m. Consultant E confirmed the lack of any behavior monitoring regarding psychotropic medications and confirmed the facility did not identify or monitor the Black Box warning medications on the residents care plan. Consultant E reported the facility received a list of BBW medications from consultant H but he/she did not know what had been done regarding the recommendations after that.

During an interview on 4-26-2012 at 5:10 p.m. consultant H reported he/she gave the facility a list of residents and the BBW medication they took that needed to be monitored in January of 2012. Consultant H reported that he/she was not sure where the facility needed to document the monitoring and did not realize the BBW needed to be included in the plan of care. Consultant H reported that he/she did not normally review the care plans with monthly reviews. He/She reported that for the behavior monitoring he/she looked at the nurses notes for documentation of behaviors.

During an interview on 4-30-2012 at 3:00 p.m. administrative nurse M reported his/her expectation was for staff to follow up on prn medications that had been administered within an hour and document the findings as to the effectiveness of the medications.

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The pharmacist failed to identify irregularities regarding the follow up of PRN (as needed) medications and their effectiveness and the facility failed to act upon the pharmacist recommendation regarding the need to monitor medications with Black Box Warnings for resident #10.

- Review of resident # 22's signed physician order sheet dated 4-4-12 included the following diagnoses: dementia with behavioral disturbance, anal fistula, renal failure, hepatitis-C, diabetes, hypertension, calculus of kidney, atherosclerosis, chronic kidney disease,, spinal stenosis of lumbar region, cardiac dysrhythmia, thrombocytopenia, anemia, depressive disorder with a current admit date of 3-16-2010.

Review of the most recent annual MDS (minimum data set) with an ARD (assessment reference date) of 2-15-2012 revealed a BIMS (brief interview for mental status score) of 9, moderate cognitive impairment. It also revealed mood, behaviors, and psychotropic medications did not trigger for further investigation.

Review of the medication administration record for the month of April revealed the resident received atenolol 25 mg (milligrams) daily for hypertension, lasix 20 mg daily for hypertension and Lortab 5/500 three times a day for pain management.

Review of the care plan dated 2-21-2012 lacked evidence of identifying atenolol, lasix or the lortab as having a BBW and the need for monitoring.

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According to BlackBoxRx.com Atenolol has a BBW not to discontinue abruptly; Lasix has a BBW that it can lead to profound diuresis,resulting in fluid and electrolyte depletion and Lotrab is a combination medication with acetaminophen which has a black box warning regarding acute liver failure and not to exceed 4 grams in 24 hours.

Observation on 4-24-12 at 9:55 am revealed the resident sat in recliner chair reading newspaper, call light within reach.

Observation on 4-26-2012 at 9:46 a.m. resident sat in recliner working with restorative aide using the pulleys for upper extremity strengthening.

During an interview on 4-24-2012 at 3:36 p.m. licensed nurse D reported the resident had a psychiatrist that came monthly to see the resident and the nurse was to call the physician if there were any changes in behaviors.

During an interview on 4-26-2012 at 10:19 a.m. Consultant E confirmed the facility did not identify and monitor the Black Box warning medications on the care plan. Consultant E reported the facility received a list of BBW medications from the Consultant but did not know what had been regarding the recommendations after that.

During an interview on 4-26-2012 at 5:10 p.m. consultant H reported he/she gave the facility a list of residents and the BBW medication they took that need to be monitored in January of 2012. Consultant H reported that he/she was not sure where they needed to document the monitoring and did not realize the BBW needed

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to be included in the plan of care. Consultant H reported that he/she did not normally review the care plan with monthly reviews. Consultant H reported that he/she did not assist the facility in developing a system for the monitoring of BBW med's.

The facility failed to act upon the pharmacist recommendation regarding the need to monitor medications with Black Box Warnings for resident #22.

- Review of resident #37's signed physician's orders dated 4/4/12 revealed the following diagnoses: presenile dementia, dementia with behavioral disturbances, closed fracture of acetabulum, closed fracture of acromial end of clavicle, cardiac pacemaker, low body weight, dementia with psychosis and behaviors, depression, pain and constipation.

Review of the most recent quarterly MDS (minimum data set) dated 3/21/12 identified the resident with a BIMS (brief interview of mental status) score of 0 (severe cognition deficit), experienced inattention, disorganized thinking, hallucinations and delusions. The MDS also identified the resident required extensive assist of 2 persons with bed mobility, transfer, walking in room and corridor, dressing toilet use and personal hygiene. The MDS revealed the resident also required limited assistance of one person with eating.

Review of the admission MDS dated 12/21/11 identified the resident with a BIMS score of 2 (severe cognition deficit), experienced inattention

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and disorganized thinking, hallucinations and delusions. The MDS also identified the resident required extensive assist of 2 persons for bed mobility, transfer, walking in room and corridor, toilet use, and dressing and limited assist of one for personal hygiene. and experienced mild pain.

Review of the cognitive CAA (care area assessment) dated 12/21/11 further assessed the resident with anxiety/agitation and behavioral disturbances, poor nutrition low weight of 115 pounds. The CAA also identified the resident experienced a short attention span, confusion, forgetfulness and disorientation. It identified the resident lived in the past through hallucinations and delusions.

The care plan dated 12/27/11 included monitoring for common ADR (adverse drug reactions) of Seroquel which included: anticholinergic effects, akasthesis, neuroleptic malignant syndrome, cardiac arrhythmia, heart failure, falls and lethargy, but failed to include the black box warning (serious or life-threatening adverse side effects) of elderly patients with dementia-related psychosis treated with a typical or conventional antipyretics are at increased risk for death and the need to monitor electrolytes.

The resident's care plan dated 12/27/11 included a revision date of 2/16/12 for staff to monitor for common adverse drug reactions for zoloft (a medication used to treat depression) which included observe and report insomnia, somnolence, dizzy, headache, tremors, fatigue, seizures, malignant syndrome like reaction, nausea and vomiting, anorexia, constipation or diarrhea. The care plan failed to include the

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F 428	Continued From page 61 black box warning for clinical worsening of suicidal thinking or changes in behavior. Review of the Pharmacy Report dated 1/25/12 revealed consultant H provided the facility with a list of residents who received medications with a BBW (black box warning) and what the staff needed to monitor regarding each drug listed. Consultant H informed the facility of the need for monitoring of the BBW for Seroquel for resident #37 which Consultant H included, suicidal thinking and electrolytes. The facility failed to include the monitoring for suicidal thinking and electrolytes on the resident's plan of care. On 4/24/12 at 4:15 p.m. administrative nursing staff L confirmed he/she did not include BBWs on the plan of care. On 4/24/12 at 5:10 p.m. administrative nursing staff M reported he/she was unaware that BBW's were to be care planned. He/She stated consultant H told the facility about 2 months ago they had to document BBWs on the nurses' notes. On 4/26/12 at 3:00 p.m. consultant E reported the facility was working on a behavioral monitoring and BBW systems but it was not in operation at this time. On 4/26/12 at 5:10 p.m. interview with consultant H revealed he/she had notified the facility of the need to monitor for black box warnings by providing the facility with a list of residents and their medications that had a BBW in January 2012. Consultant H reported he/she was unaware that the black box warnings needed to	F 428		

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be included in the plan of care or what else he/she was to do with the BBWs. Consultant H reported he/she did not review care plans during his/her monthly reviews. Consultant H confirmed he/she had not done anything further with BBWs. Consultant H reported he/she did not assist the facility in developing any system or policy's regarding black box warnings.

The facility provided no policy regarding the monitoring of black box warnings.

The facility failed to act upon the pharmacists' recommendation regarding the need to monitor for BBWs for a resident who received medications with a black box warning.

- Review of resident #7's signed Physician's Order Sheet (POS) and dated 4-1-2012 revealed the resident with the following medical diagnoses: depressive disorder, osteoarthrosis, major depressive affective disorder, senile demential with delusional or depressive features, osteoporosis, and psychosis.

Review of the annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 10-20-11 identified the resident with a BIMS score of 12, moderate cognitive impairment. He/she experienced disorganized or incoherent, unclear or illogical flow of ideas, or unpredictable switching from subject to subject. The resident did not have mood problems or behaviors.

Review of the resident's cognitive loss/dementia Care Assessment Area (CAA's) dated 10-10-11 revealed he/she had no negative moods or

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behaviors.

Review of the resident's psychotropic medication use CAA dated 10-10-11 revealed he/she was doing well with reduction of the abilify dose and had no signs or symptoms of adverse reactions from the remeron, effexor, and abilify.

The resident's care plan dated 10-20-11, updated 1-24-12 and 4-24-12, directed staff to report hallucinations or delusions to the nurse, attempt to discover possible underlying cause of hallucinations or delusions, and provide an assessment for physical complaints. It also directed staff to monitor for an increase in negative behaviors and anxiety. The care plan contained common side effects for staff to monitor but it failed to address the monitoring of potential severe side effects (black box warning) regarding aripirrazole, mirtazapine, and venlafaxine.

Review of the resident's pharmacy consult notes dated 1-25-12 identified Black Box Warning (BBW) for aripiprazole, mirtazapine, and venlafaxine regarding increased risk for suicidal thinking and death.

Review of the resident's Medication Administration Record (MAR) revealed lortab administered as needed for pain 13 times during March 2012 and 10 times from 4-2-12 through 4-23-12 but staff failed to document the effectiveness on the MAR.

Observation on 4-24-12 at 10:13 am revealed resident #7 at the sink brushing his/her teeth. The resident propels him/her self in the room without

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F 428	Continued From page 64 difficulty. Observation on 4-26-12 at 9:35 am revealed the resident participated in the "get fit activity". An interview on 4-26-12 at 2:50 PM with administrative nursing staff L confirmed the resident's plan of care lacked interventions for monitoring black box warnings. An interview on 4-26-12 at 3:00 PM with Consultant E confirmed the resident's plan of care lacked monitoring for BBW. An interview on 4-30-12 at 3:00 PM with administrative nursing staff M reported the expectation of staff was to follow up on administered as needed medications within an hour of providing and to document the effectiveness of the medications. An interview on 4-30-12 at 4:00 PM with licensed nursing staff T revealed he/she often did not document the effectiveness of the lortab. Staff T indicated he/she was aware it needed to be done but did not have time. The facility did not provide a policy for administration of as needed medications or black box warnings. Review of the facilities Administering Pain Medications policy dated 2/01/2005 revealed the policy lacked direction for the documentation on the effectiveness of as needed pain medications. The pharmacist failed to identify irregularities regarding the follow up of PRN (as needed)	F 428		

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medications and their effectiveness and the facility failed to act upon the pharmacist's recommendation regarding the need to monitor medications with black box warnings for this resident.

- Review of resident #33's signed Physicians's Order Sheet and dated 4-1-12 revealed the resident with the following diagnoses: hypothyroidism, diabetes mellitus, and depressive disorder.

The MDS dated 3-14-2012 identified the resident with a BIMS score 00 on a scale of 00-15, experienced an acute onset of mental status changes and received an antidepressant. The assessment also revealed he/she required the assist of one person for most activities of daily living and was not steady with transfers or position changes.

Review of the resident's Psychotropic Risk CAA revealed the resident received Remeron and Paxil for depression and appetitive stimulant. The CAA indicated the resident did experienced delirium but the psychotropic medications were not assessed to be the likely cause.

Review of the care plan updated 4-2-12 directed staff to discontinue paxil and initiate xanax as needed for anxiety and restlessness. The update instructed staff to monitor and report possible side effects including dizziness, drowsiness, orthostatic hypotension, tachycardia, blurred vision, and rash.

Review of the care plan updated 4-17-12 instructed staff to initiate luvox and to observe

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and report side effects including headache, drowsiness, dizziness, seizures, neurological malignant syndrome, rash, sweating, nausea or vomiting, constipation, diarrhea, and hepatotoxicity. The care plan lacked monitoring of the black box warning for suicidal thinking. The care plan also revealed the staff failed to include and monitor black box warnings for metformin related to lactose acidosis and tylenol not to exceed 4 grams daily and monitor for hepatotoxicity..

Review of the resident's MAR dated 4 1-12 through 4-26-12 revealed he/she received Xanax 28 times but staff failed to document the effectiveness on back of the MAR 10 times.

Observation on 4-23-12 at 4:22 PM revealed the resident sleeping quietly in bed.

Observation on 4-24-12 at 1:21 PM revealed the resident sat in the wheelchair and propelled self down the hall.

Observation on 4-26-12 at 12:00 PM revealed the resident up in recliner. The resident is yelling out "help, help, help" and staff responded and attempted to calm the resident by offering a drink, providing 1 on 1, and repositioned him/her into the wheelchair.

Interview on 4-23-12 with direct care staff K at 4:18 PM revealed he/she would go to the charge nurse, director of nursing, or look in the care plan when seeking information on how to care for resident..

Interview on 4-26-12 with administrative nursing

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F 428	Continued From page 67 staff L at 2:50 PM reported the resident's plan of care lacked monitoring for black box warnings. Interview on 4-26-12 with licensed Consultant E at 3:00 PM confirmed the resident's plan of care lacked monitoring for black box warnings. During a telephone interview on 4-30-12 with administrative nursing staff M at 3:00 PM revealed the expectation of staff was to follow up on as needed medications within one hour of administration and document the effectiveness of the medications. The pharmacist failed to identify irregularities regarding the follow up of PRN (as needed) medications and their effectiveness and the facility failed to act upon the pharmacist recommendation regarding the need to monitor medications with black box warnings for this resident. - The Review of resident # 6's signed physician orders dated 4/10/12 revealed the following diagnoses: acute onset of chronic respiratory failure congestive heart failure, stage 4 sarcoidosis/fibrosis, hypertension, depression, allergies, broncho spasms, insomnia, hypothyroidism, constipation, esophageal reflux disease, hemorrhoids. The review of the significant change MDS (minimum data set) with an ARD (assessment reference date) of 4/19/12 revealed a BIMS (brief interview for mental status) of 14 (cognitively intact). The medication section of the MDS revealed a use of antidepressant and antianxiety medications.	F 428		

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F 428	Continued From page 68 The psychotropic drug use CAA (care area assessment) dated 4/19/12 revealed the resident took Lorazepam and Celexa. The resident had chronic years of Lorazepam use with previous unsuccessful attempts to stop the medication. Review of the care plan dated 2/6/12 included common side effects for Celexa (antidepressant) and APAP (Acetaminophen) but lacked interventions for monitoring and reporting of specific or severe side effects of BBW (black box warning) medications. The care plan failed to identify common and severe side effects for Lasix. According to" BlackBoxRx.com" website Celexa has BBW regarding for clinical worsening suicdality or unusual changes in behavior, Acetaminophen, regarding acute liver failure and not to exceed a maximum dose of 4000 mg (milligrams) in 24 hours, Lasix lead to profound diuresis with water and electrolyte depletion. Review of the medication administration sheets revealed that the facility did not follow up for responses for the PRN of the given PRN (as needed) medications administered on the following dates of the following medications: Mylanta on 1/24/12, 3/10, 3/11, 3/12, 3/26/12 Ambien on 4/10/12 Ducolax on 2/13, 2/26/12 Lorazepam on 1/26, 3/14, 3/16, 3/17, 3/26/12 Tylenol on 1/26, 3/14, 3/21, 3/24/12	F 428		

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On 4/24/12 at 10:00 a.m. observation revealed the resident smiled and talked softly to direct staff U. The resident did not avoid eye contact when talking.

On 4/26/12 at 12:10 p.m. observation revealed the resident smiled at staff member V, who assisted the resident in the dining room.

During an interview on 4/26/12 at 10:19 a.m., Consultant E confirmed the facility did not identify and monitor for BBW medications on the residents' plan of care. Consultant E confirmed the facility received a list of BBW medications from the pharmacist on 1/25/2012 but did not know what happened to them after that.

On 4/26/12 at 11:05 a.m., licensed nursing staff T reported that he/she had worked with the physician to get the pain medications reduced and changed around to work better. Staff T stated that staff was to chart the PRN's (as needed) and their effectiveness on the PRN sheet.

On 4/26/12 at 5:10 p.m., an interview with consultant H revealed he/she provided the facility a list of resident # 6's Black Box Warnings for Celexa and Lasix dated 1/25/12. He/she reported that he/she was not sure where that needed to be documented. Consultant H reported he/she did not realize the BBW needed to be included in the care plan. Consultant H reported that he/she did not normally review the care plan with monthly reviews and did not assist the facility in developing a system for the monitoring of BBW medications.

During an interview with Administrative staff M on

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4/30/12 at 3:00 p.m. he/she reported that the expectation was for staff to follow up on the PRN (as needed) medications that had been administered within 1 hour and document the effectiveness of the medication.

The facility failed to provide a policy on the monitoring of the BBW's and the PRN medications.

The pharmacist failed to identify irregularities regarding the follow up of PRN medications and their effectiveness and the facility failed to act upon the pharmacist recommendation regarding the need to monitor medications with Black Box Warnings for resident #6.

- The Review of resident # 16's signed physician orders dated 3/4/12 revealed the following diagnoses: chronic obstructive pulmonary disease, restless leg syndrome, coronary artery disease, diabetes mellitus, hypertension, gastro-esophageal reflux disease, fibromyalgia, and osteopenia.

Review of the significant change MDS (minimum data set) with an ARD (assessment reference date) of 4/18/12 revealed that the resident experienced mood problems. The resident had little interest, or pleasure in doing things 2-6 days, feeling down for 2-6 days, trouble falling asleep or staying asleep or sleeping to much 7-11days during the 14 day look back period. The resident reported being tired with little energy 2-6 days; poor appetite/overeating 12-14 days during the 14 day look back period. He/she also had trouble concentrating and feeling bad about his/herself

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2-6 days of the look back period of 14 days. The psychosocial well- being CAA (care area assessment) dated 4/19/12 identified the resident experienced behavior problems prior to admission to the facility.

Review of the care plan dated 4/25/12 revealed Effexor and Lasix was care planned for common side effects; but failed to identify and direct staff to monitor for BBW for the following medications Effexor, Metoprolol, and Lasix. According to "BlackBoxRx.com" for Metoprolol not to discontinue abruptly due to cardiac risk, and Lasix, may lead to profound diuresis with water and electrolyte depletion if given in excessive amounts. Effexor not to discontinue the medication abruptly the dose should be tapered over a 2 week period of time.

Review of the medication administration sheets dated April 2012 indicated the staff failed to follow up of the given PRN (as needed) medications done for the following dates and the following medications:

Oxycodone on 2/5, 2/22 times 2, 2/25, 2/28, 2/29, 3/1, 3/2, 3/5, 3/8/ 3/10, 3/11, 3/13, 3/14, 3/24, 3/30, 3/31, 4/1 times 2, 4/3, 4/6, 4/7, 4/8, 4/10, 4/12, 4/14/12.

Maalox on 3/6/12.

Tylenol on 2/12 times 2, 2/20 x's 2, 2/22, 2/25, 2/27, 2/28, 3/4, 3/4, 3/18/12

Tordol on 3/10, 3/11, 3/15, 3/18/12

Ibuprophen on 3/11, 3/12, 3/15, 3/20, 3/18, 3/20,

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F 428	Continued From page 72 3/24, 3/26, 4/2, 4/8, 4/10, 4/20 times 2, 4/21, 4/22, 4/23 times 2, 4/24/ times 2, 4/25 times 2, 4/26/12 Miralax on 2/1, 2/2, 2/5, 2/7, 2/9, 2/26, 3/3, 3/15, 3/18, 4/12, 4/13, 4/15, 4/17/12. On 4/24/12 at 11:45 a.m. observation revealed the resident finished the care plan meeting and sat in his/her room crying. On 4/26/12 at 10:30 a.m.,observation revealed the resident visited freely with his/her roommate and without behaviors noted. During an interview on 4/26/12 at 10:19 a.m., Consultant E confirmed the facility did not identify and monitor for BBW medications on the residents' plan of care. Consultant E confirmed the facility received a list of BBW medications from the pharmacist on 1/25/2012 but did not know what happened to them after that. On 4/26/12 at 11:05 a.m., licensed nursing staff T reported that he/she had worked with the physician to get the pain medications reduced and changed around to. Staff T stated that staff was to chart the PRN's (as needed) and their effectiveness on the PRN sheet. On 4/26/12 at 5:10 p.m., an interview with consultant H revealed he/she provided the facility a list of resident # 6's Black Box Warnings for Effexor, Metoprolol and Lasix dated 1/25/12. He/she reported that he/she was not sure where it needed to be documented in the record. Consultant H reported he/she did not realize the BBW needed to be included in the care plan.	F 428		

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Consultant H reported that he/she did not normally review the care plan with monthly reviews and did not assist the facility in developing a system for the monitoring of BBW medications.

During an interview with Administrative staff M on 4/30/12 at 3:00 p.m. he/she reported that the expectation was for staff to follow up on the PRN (as needed) medications that had been administered within 1 hour and document the effectiveness of the medication.

The facility failed to provide a policy on the monitoring of the BBW's and the PRN medications.

The pharmacist failed to identify irregularities regarding the follow up of PRN medications and their effectiveness and the facility failed to act upon the pharmacist recommendation regarding the need to monitor medications with Black Box Warnings for resident #16.

- The Review of resident #13's signed physician orders dated 3/20/12 revealed the following diagnoses; diabetes mellitus with out of complications type 2, chronic obstructive asthma, diabetic renal complications, depressive disorder, nephritis and nephropathy lesion in the kidney, chronic kidney disease, exocytosis of nasal mucosa chest pain personal history of urinary tract infection multiple, congestive heart failure, traumatic amputation of the right leg, constipation, neurological manifestations from diabetes, morbid obesity, essential hypertension, osteoarthritis, generalized atherosclerosis, old myocardial infarction, with stent, angioplasty

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hyperlipidemia esophageal reflux disease.

Review of the annual MDS (minimum data set) with an ARD (assessment reference date) of 12/15/11 and a BIMS (brief interview of mental status) score of 15 indicating the resident is cognitively intact. Overall presents of behavioral symptoms indicate the resident has had the following verbal and behavioral symptoms directed toward others

Review of the cognative/loss CAA (care area assessment) dated 3/22/12 revealed the residents cognitive status was intact though the resident had negative behaviors

Review of the care plan dated 1/17/12 care planned the more common side effects of Celexa but failed to identify the more serious BBW (black box warning) for Celexa and Bumex. According to "BlackBoxRx.com" website Celexa has BBW regarding for clinical worsening sociality or unusual changes in behavior. Bumex related to the monitoring of the serum electrolyte, creatinine and BUN.

Review of the medication administration sheets indicate that no follow up of given PRNs on the following dated of the following medications:

Mylanta on 1/15, 1/18 x's 2, 3/10, 3/12, 3/14/12 on the PRN sheet

Tusselon Perles on 4/24, 4/25 x's2, 4/26 x's 2 on the PRN sheet

Musinex on 4/24, 4/26/12 on the PRN sheet

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Sildec on 3/24 x's 2, 3/25, 3/26, 3/27, 3/28 x's 2 3/29 x's 3, 3/30 x's 2, 3/31 x's 3 on the PRN sheet.

Milk of Magnesia on 3/10, 3/15/12

Ducolax Suppository on 2/1, 2/11, 3/10, 3/16/12

Tylenol on 3/10/12

Lortab on 1/2, 1/3, 1/15, 2/5, 2/12 x's 2 2/13, 2/17, 2/22 x's 2, 2/24, 2/26, 2/29, 3/1, 3/2, 3/4, 3/5, 3/7, 3/8, 3/9, 3/10 x's 2, 3/11, 3/12, 3/13, 3/14, 3/15, 3/16, 3/18, 3/20, 3/21, 3/23, 3/24 x's 2, 3/25 x's 4, 3/26, 3/28, 4/19 x's 2, 4/21, 4/22 x's 2, 4/24/12

On 4/23/12 at 2:00 p.m. observation made of the resident sitting in the living room in a large recliner watching television. Resident interacted with both the residents and the staff, resident smiled.

On 4/23/12 at 3:15 p.m. observation of the resident revealed her frowning and yelling, and accused staff of wrong doings. Resident blamed the staff for not leaving his/her with the call light earlier but the staff were still in the room with his/her at the time.

During an interview on 4/26/12 at 10:19 a.m., Consultant E confirmed the facility did not identify and monitor for BBW medications on the resident' care plan. Consultant E confirmed the facility received a list of BBW medications from the pharmacist on 1/25/2012 but did not know what happened to them after that.

On 4/26/12 at 11:05 a.m., licensed nursing staff T

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F 428	Continued From page 76 had reported that he/she had worked with the physician to get the pain medications reduced and changed around. Staff T stated that staff was to chart the PRN's (as needed) on the PRN sheet and then chart the effectiveness of the medication. On 4/26/12 at 5:10 p.m., an interview with consultant H revealed he/she provided the facility a list of resident # 6's Black Box Warnings for Celexa and Bumex dated 1/25/12. He/she reported that he/she was not sure where that needed documenting. Consultant H reported he/she did not realize the BBW needed to be included in the care plan. Consultant H reported that he/she did not normally review the care plan with monthly reviews and did not assist the facility in developing a system for the monitoring of BBW medications. The facility failed to provide a policy on the monitoring of the BBW's and the PRN medications. During an interview with Administrative staff M on 4/30/12 at 3:00 p.m. he/she reported that the expectation was for staff to follow up on the PRN (as needed) medications that had been administered within 1 hour and document the effectiveness of the medication. The pharmacist failed to identify irregularities regarding the follow up of PRN medications and their effectiveness and the facility failed to act upon the pharmacist recommendation regarding the need to monitor medications with Black Box Warnings for resident #13.	F 428		
F 441	483.65 INFECTION CONTROL, PREVENT	F 441		

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F 441 SS=C	Continued From page 77 SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.	F 441		

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F 441	Continued From page 78 This REQUIREMENT is not met as evidenced by: The facility reported a census of 35 residents. Based on observation, interview and record review the facility failed to develop policies for cleaning of resident floors and surfaces in isolation rooms to prevent the transmission of diseases including C-Diff (clostridium difficile). The facility practices had the potential to affect all 35 residents. Findings included: - Record review of the Becto Distributor literature item #32592-92, PH7Q ultra will kill HIV-1 (aids virus), HBV (hepatitis B virus), HEP-C (Hepatitis- C), Staphylococcus areas, Pseudomonas aeruginosa, Samonella, VRE (vancomycin resistant entercoccus Faecalis), MRSA (Methacillin Resistant Staphylococcus areus), Herpes simplex, H1N1 (influenza), but did not include C-Diff. Review of the CDC (center for disease control) guidelines on cleaning and disinfecting of Isolated areas located at www.cdc.gov website included the following recommendations. EPA-registered disinfectants are recommended for use in patient-care areas. When choosing a disinfectant, check product labels for inactivation claims, indications for use, and instructions. Ensure adequate cleaning and disinfection of environmental surfaces and reusable devices, especially items likely to be contaminated with feces and surfaces that are touched frequently. Consider using an Environmental Protection Agency (EPA)-registered disinfectant with a	F 441		

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sporicidal claim for environmental surface disinfection after cleaning in accordance with label instructions; generic sources of hypochlorite (e.g., household chlorine bleach) also may be appropriately diluted and used. (Note: Standard EPA-registered hospital disinfectants are not effective against Clostridium difficile spores .) Hypochlorite-based disinfectants may be most effective in preventing Clostridium difficile transmission in units with high endemic rates of Clostridium difficile infection.

Observation on 4/24/12 at 9:30 a.m. revealed housekeeping staff J mopped the floor in 1 resident's room on the South hall.

Observation on 4/26/12 at 10:15 a.m. revealed housekeeping staff P mopped the floor in another resident's room on the North hall.

Interview on 4/26/12 at 11:30 a.m. revealed housekeeping staff P used pH7Q ultra (a broad spectrum disinfectant) for all the floors and surfaces (sinks, fixtures, and toilets).

On 4/26/12 at 5:00 p.m. during an interview with consultant E he/she attempted to find a policy on disinfecting a room after isolation. Consultant E confirmed the facility had no policy that addressed C-Diff and/or the disinfecting of resident's rooms after being occupied by a resident with C-Diff. Consultant E confirmed the facility did not have any residents currently with C-Diff.

The facility failed to develop policies for the cleaning of resident rooms and floors to prevent transmission of diseases and C- Difficile.

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